Send completed form by fax or email to the following:

CMS Provider Management
Fax: (850) 487-1279
Email: cmsproviderhelp@doh.state.fl.us

Provider Attestation Form

As a Children's Medical Services Provider, I attest to the following:

I fully understand that any significant misstatement or omission from this application constitutes cause for denial of approval or cause for summary termination from participating as a provider with Children's Medical Services (CMS). All information submitted by me in this application is true to the best of my knowledge and belief.

I have read the CMS Provider Handbook and hereby voluntarily agree to provide services to CMS patients in accordance with the standards presented within that document.

I hereby apply to participate in CMS and authorize CMS, through its agents and employees, to contact any and all agencies, institutions, and persons listed herein for the purpose of obtaining background data, information, and records relevant to my application. I further authorize, and agree to hold harmless, all agencies, institutions, and person listed herein to release to CMS, upon request, background data, information, and records relevant to my application, including records that might be otherwise confidential or exempt from the public records law of the State of Florida. Confidential or exempt records released to CMS pursuant to this authorization shall otherwise retain their confidential or exempt status. A copy of this authorization to release information shall be deemed as valid as the original.

_____ _____
Signature of Applicant Date

_____
Print name of Applicant

NOTE: This form must be signed within (30) days of request by CMS Provider Management or it will be considered invalid.